CORPORATE BACKGROUND AND EXPERIENCE

1. Corporate Information

- **Name**
- **Address**
- **Telephone Number**
- **Fax Number**
- **E-Mail Address**

1) Unison Health Plan of Tennessee, Inc.'s Corporate Information

Unison Health Plan of Tennessee, Inc.
890 Willow Tree Circle, Suite 10
Cordova, TN 38018
Phone: (901) 737-7095
Fax: (901) 737-1420
E-Mail: matthew.moore@unisonhealthplan.com

2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization

- **Name**
- **Address of Corporate Headquarters**
- **Telephone Number**
- **Fax Number**
- **E-Mail Address**

2) Unison Health Plan of Tennessee, Inc.'s Corporate Information of Our Parent Organization

Unison Health Plan of Tennessee, Inc. is a wholly-owned subsidiary of Three Rivers Holdings, Inc., a privately held Delaware corporation. Below you will find the corporate information for Three Rivers Holdings, Inc.

Three Rivers Holdings, Inc.
c/o Dobbs Management Services, LLC
1000 Ridgeway Loop Road, Suite 203
Memphis, TN 38210
Phone: (901) 684-1082
Fax: (901) 684-1830
E-Mail: bill@dobbsmanagement.com

3. State of incorporation or where otherwise organized to do business

3) Unison Health Plan of Tennessee, Inc.'s State of Incorporation

Unison Health Plan of Tennessee, Inc. is incorporated to do business in the State of Tennessee.

4. States where currently licensed to accept risk and a description of each license

4) Unison Health Plan's Licensure of Risk and License Description

Unison Health Plan includes companies that are licensed to accept risk in Pennsylvania, Tennessee, South Carolina, and Ohio as follows:

- Unison Health Plan of Pennsylvania, Inc. (formerly known as Three Rivers Health Plans, Inc.), NAIC Number 95220, is a wholly owned subsidiary of Three Rivers Holdings, Inc. that has been licensed as a Pennsylvania Health Maintenance Organization since 1996 and operates both a Medicaid and a Medicare managed care plan on an at-risk basis.
- Unison Family Health Plan of Pennsylvania, Inc. (formerly known as Three Rivers Children's Health Plan, Inc.), NAIC Number 12012, is a wholly owned subsidiary of Unison Health Plan of Pennsylvania, Inc. that has been licensed as a Pennsylvania Health Maintenance Organization since 2004 and operates both a SCHIP and Pennsylvania adultBasic managed care plan on an at-risk basis.
- Unison Health Plan of Tennessee, Inc. (formerly known as Better Health Plans, Inc.), NAIC Number 11139, is a wholly owned subsidiary of Three Rivers Holdings, Inc. that has been licensed as a Tennessee Health Maintenance Organization since 2001 and operates a TennCare managed care plan that is currently funded on an ASO basis.
- Unison Health Plan of South Carolina, Inc. (formerly known as Better Health Plans of South Carolina, Inc.), NAIC Number 11775, is a wholly owned subsidiary of Three Rivers Holdings, Inc. that has been licensed as a South Carolina Health Maintenance Organization since 2004 and operates a Medicaid managed care plan on an at-risk basis.
- Unison Health Plan of Ohio, Inc., NAIC Number 12323, is a wholly owned subsidiary of Unison Health Holdings of Ohio, Inc., which in turn is a wholly owned subsidiary of Three Rivers Holdings, Inc. This company has been licensed as an Ohio Health Insuring Corporation since 2005 and operates a Medicaid managed care plan on an at-risk basis.
- In addition, Unison Health Plan of New Jersey, Inc., a wholly owned subsidiary of Three Rivers Holdings, Inc., recently filed an application to be licensed as a New Jersey Health Maintenance Organization.

Copies of the licenses described are available upon request.

5. Contact Information

- **Name**
- **Title**
- **Telephone Number**
- **Fax Number**
- **E-Mail Address**

5) Unison Health Plan of Tennessee Inc.'s Contact Information

For additional information or questions, please contact Mr. Matthew Moore, Executive Director of Unison Health Plan of Tennessee, Inc. Mr. Moore's contact information is listed below:

Mr. Matthew Moore
Executive Director of Unison Health Plan of Tennessee, Inc.
Phone: (901) 737-7095
Fax: (412) 457-1428
E-Mail: matthew.moore@unisonhealthplan.com

6. Program Experience - General

Given TennCare's history with small, inexperienced plans becoming insolvent, the State is in interested in contracting with MCOs that have substantial experience with capitation, particularly for the Medicaid population. Tennessee also intends to require that all MCOs be NCQA-accredited or receive NCQA-accreditation for the Medicaid product within a specified time period after contract award.

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

6 a) Unison Health Plan's Medicaid Experience under Capitation

Unison Health Plan of Tennessee, Inc. has been participating in the TennCare program since July 1, 2001. Payment was at-risk capitation until the Bureau of TennCare initiated change on July 1, 2002. Since this date, Unison Health Plan of Tennessee, Inc. has been operating under a non-capitated administrative services-only agreement.

Unison Health Plan has almost 10 years of experience working under capitated Medicaid agreements as well as capitated agreements for the Medicare, SCHIP, and other state-sponsored health insurance programs.

Unison Health Plan's experience is listed below:

- Unison Health Plan of Pennsylvania, Inc., our Pennsylvania affiliate, has been working under three capitated, at-risk, Medicaid managed care contracts since as early as April 1996. The Pennsylvania affiliate has also been working under a capitated, at-risk Medicare managed care contract since May 2005.
- Unison Family Plan of Pennsylvania, Inc., our Pennsylvania affiliate serving SCHIP consumers, has been working under a capitated, at-risk managed care contract since September 1999. Unison Family Plan has also been working under a capitated, at-risk managed care contract known as adultBasic since July 2005.
- Unison Health Plan of South Carolina, Inc., our South Carolina affiliate, has been working under an at-risk capitated agreement since November 2004.
- Unison Health Plan of Ohio, Inc., our Ohio affiliate, recently began operating under an at-risk capitated agreement on November 1, 2005.

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product line? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

6 b) Unison Health Plan's Current Accreditation Status

Unison Health Plan of Tennessee, Inc. has not yet been awarded an NCQA-accreditation for our Medicaid product line in West Tennessee. We are looking forward to our first NCQA accreditation review that is scheduled for September 2006. This accreditation would also be effective for the Middle Tennessee region.

Unison Health Plan of Tennessee, Inc.'s affiliate, Unison Health Plan of Pennsylvania, Inc., was awarded a three-year “excellent” NCQA accreditation in 2002. We recently completed our three year resurvey and fully expect a three year renewal with similar results. In addition, NCQA and

U.S. News & World Report recently ranked our Pennsylvania Medicaid product as #16 among all Medicaid plans nationwide based on clinical quality, member satisfaction and NCQA Accreditation.

Unison Health Plan tracks selected indicators of performance to identify areas that require further evaluation and may require improvement. These indicators cover program, clinical, and service activities and are selected based on an analysis of encounter data, member demographic information, and results of HEDIS, CAHPS, and External Quality Review (EQR) measurement outcomes. Additional indicators are included to meet contract requirements and recommendations made by the NCQA.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

6 c) Unison Health Plan's Current Medicaid Contracts

In addition to serving Medicaid consumers in Tennessee, Unison Health Plan's affiliates are currently under contract in Pennsylvania, South Carolina, and Ohio to provide Medicaid services.

7. Medicaid Program Experience - Services

Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

a. **Physical Health Benefits**
b. **Dental Benefits**
c. **Vision Benefits**
d. **Non-Emergency Transportation**
e. **Behavioral Health Benefits**
f. **Pharmacy Benefits**
g. **Long-Term Care Benefits (nursing facility and home and community based waiver services)**
h. **Home Health**
i. **Claims Processing and Adjudication**
j. **Quality Assurance**
k. **Utilization Management**
l. **Case Management**
m. **Disease Management**
n. **Provider Credentialing**
o. **Enrollment Assistance**
p. **Member Services (inquiry, id cards)**
q. **Member Grievances/Appeals**

7) Unison Health Plan's Medicaid Program Experience - Services

	Tennessee	Pennsylvania				South Carolina	Ohio
	Medicaid	Medicaid	Medicare	SCHIP	adultBasic	Medicaid	Medicaid
a. Physical Health Benefits	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
b. Dental Benefits	1) No	1) Yes 2) Direct	1) Yes (except dual eligibles) 2) Direct	1) Yes 2) Direct	1) No	1) Yes (adults only) 2) Direct	1) Yes 2) Subcontract
c. Vision Benefits	1) Yes 2) Subcontract	1) Yes 2) Subcontract	1) Yes 2) Subcontract	1) Yes 2) Subcontract	1) No	1) Yes 2) Subcontract	1) Yes 2) Subcontract
d. Non-Emergency Transportation	1) Yes 2) Subcontract*	1) No	1) No	1) No	1) No	1) No	1) Yes 2) Subcontract
e. Behavioral Health Benefits	1) No	1) No	1) Yes 2) Subcontract	1) Yes 2) Subcontract	1) No	1) No	1) Yes 2) Direct
f. Pharmacy Benefits	1) No	1) Yes 2) Subcontract*	1) Yes 2) Subcontract*	1) Yes 2) Subcontract*	1) No 2) Subcontract to provide discount plan	1) Yes 2) Subcontract*	1) Yes 2) Subcontract*
g. Long-Term Care Benefits (nursing facility and home and community-based waiver services)	1) No	1) Yes (up to 30 continuous days) 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) No	1) Yes (first 30 days) 2) Direct	1) Yes (until state determines disenrollment) 2) Direct
h. Home Health	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
i. Claims Processing and Adjudication**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
j. Quality Assurance**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
k. Utilization Management**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
l. Case Management**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
n. Provider Credentialing**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
o. Enrollment Assistance**	1) Yes 2) Direct	1) No	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
p. Member Services (inquiry, id cards)**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct
q. Member Grievances/Appeals**	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct	1) Yes 2) Direct

* Although Unison Health Plans subcontracts to provide this service, there is no downstream risk to our vendor.

**Unison Health Plan of Tennessee, Inc.'s affiliated health plan management company, Unison Administrative Services, LLC, conducts operations for all affiliated health plans and provides the administrative services that are listed as i. - q. under an outsourcing contract.

8. Medicaid Program Experience - Population

Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

- **Aged, Blind, and Disabled - excluding dual eligibles**
- **Dual Eligibles: individuals eligible for both Medicaid and Medicare**
- **TANF and TANF-Related**
- **SCHIP**
- **Waiver Expansion Population (low-income uninsured)**
- **SPMI (Seriously and Persistently Mentally Ill)**
- **SED (Seriously Emotionally Disturbed Children/Youth)**

8) Unison Health Plan's Medicaid Experience – Population*

	Tennessee	Pennsylvania	South Carolina	Ohio
Aged, Blind, and Disabled - excluding dual eligibles	5,115	39,311	288	0
Dual Eligibles: individuals eligible for both Medicaid and Medicare	9,264	23,942	0	0
TANF and TANF-Related	36,386	138,395	2,821	9,674
SCHIP	0	9,515	0	0
Waiver Expansion Population (low-income uninsured)	2,072	10,967	59	2,421
SPMI (Seriously and Persistently Mentally Ill)	0	**	0	0
SED (Seriously Emotionally Disturbed Children/Youth)**	0	**	0	0

* Population figures are reflective of membership as of November 15, 2005.

** Unison Health Plan does contract to cover those persons who are Seriously and Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed Children/Youth (SED), however, these individuals are included in the respective membership categories of *Aged, Blind, and Disabled* and *TANF and TANF-Related*.

9. Medicaid Program Experience - Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

9) Unison Health Plan's Medicaid Experience - Payment Methodology

	Tennessee	Pennsylvania	South Carolina	Ohio
Full-Risk	No	Yes	Yes	Yes
Partial Risk	Yes	No	No	No
Shared Risk	No	No	No	No

Unison Health Plan participates in programs that include financial incentives in its Tennessee, Pennsylvania, and Ohio markets. In Tennessee, ten percent of the administrative payment is at-risk for meeting certain performance standards as to the following aspects of managed care: medical expense; generic utilization; NCQA accreditation; EPSDT compliance; and inpatient admissions. Additionally, there is a 15% bonus opportunity for meeting certain thresholds related to the same aspects of managed care. Pennsylvania is in the process of implementing incentives for plans to meet certain HEDIS measures such as cholesterol management, breast cancer screenings, and prenatal care statistics. The total incentive equals 0.5% of the premium and

payout is based on achievement of benchmarks such as the 50th, 75th and 90Th percentile, as well as a significant improvement in those measures. In Ohio, one percentage point of the administrative budget is at-risk for meeting certain performance standards related to quality of care, provider access, consumer satisfaction, administrative capacity, and clinical performance measures. Additionally, up to $250,000 is available for MCOs that achieve an excellent and/or superior rating on those performance standards.

10. Experience - Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

10) Unison Health Plan's Experience - Former Medicaid and/or Commercial

This question is not applicable to Unison Health Plan as we currently provide Medicaid program services in Tennessee, Pennsylvania, South Carolina, and Ohio. Please note that Unison Health Plan has never withdrawn from any product or market in which it has commenced business.

11. Reformed Managed Care Model

As part of its reform efforts, the State of Tennessee intends to return to a capitated managed care delivery system. The State is interested in contracting with experienced plans that are capable of coordinating services across the full continuum of care - from preventive and primary care services to long-term care services, as well as across physical and behavioral health conditions. The MCO benefit package will include behavioral health services, but long-term care services and pharmacy services will continue to be carved-out. As part of this emphasis on management and coordination of care the State intends to include a strengthened disease management strategy designed to manage high cost conditions and to manage care across the continuum of service.

A. <u>Behavioral Health</u>

Unlike the current program, the State intends to coordinate behavioral and physical health services through the MCO relationship in order to improve coordination of care. This decision results from (a) the State's previous experience with disputes between the MCO and BHO regarding the responsibilities of each entity for particular patients or diagnoses and (b) the high proportion of behavioral health products and services provided by general and family practitioners and pediatricians, currently beyond the reach of the BHO's expertise. The State also seeks to expand its options relative to the likely bidding pool in order to ensure participation of the broadest array of experienced candidates. Thus, both single-entity, "pure-play" BHOs and MCOs, as well as integrated health plans may participate; however, the MCO would be expected to be the primary contractor and to fully manage and coordinate an enrollee's physical health and behavioral health conditions.

1. **Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provided and to what populations. Please specify if you serve individuals with serious emotional**

disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

11 A 1) Unison Health Plan's Current Responsibilities for Providing Behavioral Health Services

Unison Health Plan currently provides behavioral health services to its Medicaid members in Ohio and its Medicare and SCHIP members in Pennsylvania.

Unison Health Plan of Ohio, Inc. directly provides behavioral health benefits for Ohio Medicaid members. While Unison coordinates with community mental health centers and other government agencies who continue to be funded via other mechanisms, Unison provides all remaining behavioral health services outside those facilities. Certain SED and SPMI members are included in this population.

Unison Health Plan of Pennsylvania, Inc. provides the behavioral health benefits for Pennsylvania Medicare and SCHIP members. For these lines of business, Unison Health Plan uses a subcontractor arrangement on a PMPM capitated basis. Unison's subcontractor is responsible for the provider network, utilization management, disease management and provider appeals. Unison is responsible for member services and physical and behavioral health care coordination.

While Unison Health Plan does not provide behavioral health services to its Medicaid members in its other markets, Unison Health Plan operates what we refer to as our Special Needs Unit to serve as the primary interface between the physical healthcare providers and the behavioral healthcare providers and whose primary responsibility it is to coordinate physical and behavioral healthcare as well as the social needs of our members in all our markets.

The Special Needs Unit includes a dedicated team of case managers who specialize in social and behavioral services, and who work to identify and manage members who present with unique and complicated issues under the philosophy that when the social and behavioral healthcare needs of an individual are being met, the physical healthcare needs are better met. The Special Needs Unit case managers also work to support clinical disease case management for members whose physical health needs are complicated by substance abuse, dependence, social, cultural and socio-economic issues.

In our Pennsylvania market, Unison Health Plan is responsible for providing physical healthcare services to members with SED and SPMI and also responsible for coordinating their behavioral healthcare services.

2. **Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.**

11 A 2) Unison Health Plan's Medical Management Model for Care Coordination and Service Integration

Unison Health Plan recognizes that the needs of members with complex and serious physical and behavioral health conditions require specific skills, experience, and support. This entails a coordinated effort among various Unison team members, primary care providers, specialists, other providers, community resources, the member, and the member's family and other community supports. In coordinating this effort, Unison's goals are to:

- Ensure that members have timely and uninterrupted access to, and receipt of, appropriate physical and behavioral healthcare services
- Facilitate communication and coordination of service delivery between primary care, specialty, ancillary, behavioral health, and community resources
- Coordinate with internal staff, including member services, utilization management, quality improvement, Special Needs Unit (Unison's social and behavioral case management unit), and pharmacy and dental, to help members access services and help ensure optimal physical and behavioral health outcomes.

As an experienced Medicaid managed care organization, Unison Health Plan has adopted internal and external processes to identify these members and to develop and implement appropriate treatment plans. These processes primarily focus on establishing a medical home, or PCP, for each member, whose primary responsibility is to serve as a single initial source for assisting members in attaining the physical and behavioral healthcare services they need. We then assist the PCP using the following methods to help identify physical and behavioral issues that might otherwise not be addressed.

Identification

In order to identify members with complex and serious physical and behavioral health conditions, Unison Health Plan will use several mechanisms reaching across various elements of plan operations. These mechanisms will include:

- Completion of an initial assessment
- Electronic sweeps of the claims system using algorithms to flag members whose claims reveal the presence of complex and serious conditions
- Internal referral mechanisms via member inquiries, provider referrals, or internal plan department referral.

Initial Assessment Tool

The Initial Assessment Tool will be mailed to all new members, and may also be used for telephone outreach during the early stages of membership. Non-respondents will be pursued appropriately. Completed responses will be recorded in a database to facilitate screening. Questions will target certain aspects of a member's physical and behavioral health to coordinate ongoing medical needs and identify opportunities for medical management.

Coordination of Care questions will address the transitional phase of a member's enrollment. Positive answers will lead to immediate educational outreach to the member about plan services. The outreach will determine what services the member is currently receiving and assist with transitioning to a participating provider if services are being provided by a non-contracted provider. A member's need for a standing referral and/or a specialist as primary care physician may be identified during this process and referred to the appropriate area for evaluation and processing.

General Well Being/Health Condition questions will allow the plan to gain a high level understanding of the member's physical and behavioral health conditions and potential needs. Positive responses within this area will be reviewed by Utilization Management staff for potential disease management programs and other case management outreach services.

Electronic Sweeps

The sweep process proactively identifies members through an automated review of medical and pharmacy claims data. The sweep will search for services used and medications dispensed in conjunction with a specific diagnosis to identify members with potentially complex and serious physical and behavioral health conditions. If a match occurs, the system automatically places an indicator on the member's record indicating the potential risk. Any members who are flagged will be further screened by Unison's clinical personnel for inclusion in disease management programs or other integrated case management services.

The claims sweep is performed on a quarterly basis, and more frequently as indicated by claims or volume.

Direct Referral

Unison Health Plan's experience in managing a Medicaid product for several years has not only led to operational functions for identification, but has taught team members to be attentive to members' special needs. Unison's internal systems support team members in identifying members with special needs, including behavioral health needs, through electronic indicators which display with membership verification. Unison Health Plan will use this internal referral system to initiate further case management, disease management, or specialized outreach support to any identified member.

Identification of members with complex and serious physical and behavioral health conditions also may be initiated by Unison's providers or directly by the member. Both the provider manual and member handbook describe the various disease management and medical management programs available through Unison, thus encouraging identification, referral, and coordination.

Treatment and Monitoring

Subsequent to identification, Unison assists with the treatment and monitoring of the conditions of members with complex and serious physical and behavioral health conditions. The case management services offered to Unison's members are provided by a cross functional team of registered nurses and social workers trained in various aspects of physical, behavioral, and social issues.

Our Experience with Ethnically and Racially Diverse Populations

As a company dedicated to managing the physical and behavioral healthcare of beneficiaries of government-sponsored healthcare programs, Unison Health Plan fully recognizes the importance of serving members in a culturally and linguistically appropriate manner. We know from direct experience that:

- Some of our members have limited proficiency with the English language. This includes members whose native language is English but who are not fully literate
- Some of our members come from other cultures that view health-related behaviors and healthcare differently than the dominant culture
- We have members from ethnically, racially and economically disadvantaged segments of society that have faced longstanding barriers to good physical and behavioral health and thus exhibit disproportionately high rates of certain diseases and conditions. Unison recognizes the existence of healthcare disparities and actively seeks to remove them at every opportunity.

Unison Health Plan is committed to ensuring that its staff, network providers, policies and infrastructure meet the diverse needs of members who face these challenges.

To this end, Unison Health Plan has a Cultural Competency program, which aims to ensure that:

- Unison Health Plan meets the unique and diverse physical, behavioral, and social needs of all members
- Unison Health Plan staff value diversity within the organization and for the members we serve
- Members with limited English proficiency have their communication needs met
- Our network providers fully recognize their own obligations in this regard and are sensitive to the cultural and linguistic differences of the Unison Health Plan members they serve.

Culturally competent healthcare requires a set of attitudes, skills, behaviors, and policies that enable the organization and staff to work effectively in cross-cultural situations. It reflects an understanding of the importance of acquiring and using knowledge of the unique health-related beliefs, attitudes, practices, and communication patterns of beneficiaries and their families to improve services, strengthen programs, increase community participation, and eliminate disparities in health status among diverse population groups.

Whenever possible, we team with public health entities and private groups having a similar charter, to share information that will guide all health service organizations in each region and community in directing resources where they will yield the most benefit. Unison Health Plan reaches out to community-based organizations that support racial and ethnic minorities and the disabled to be sure that the community's existing resources for members having special needs are used to their full potential. The goal is to coordinate the deployment of both community and physical and behavioral health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

a. Please provide your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

11 A 3 a) Unison Health Plan's Experience Serving Individuals with SED and SPMI

As Unison Health Plan is solely focused on contracting with government agencies to serve Medicaid and other recipients of government-sponsored programs, we understand the need to reduce the gaps in service provision for those individuals with special needs such as SED and SPMI. As such, Unison employs a dedicated team of case managers, or Special Needs Unit, who specialize in social and behavioral services, and who work to identify and manage members who present with unique and complicated issues under the philosophy that when the social and behavioral healthcare needs of an individual are being met, the physical healthcare needs are better met. The Special Needs Unit case managers also work to support clinical disease case management for members whose physical healthcare needs are complicated by substance abuse, dependence, social, cultural and socio-economic issues. The Special Needs Unit includes registered nurses and social work case managers with specific behavioral health training. Unison recognizes and addresses this critical need for coordination of care with respect to the physical, behavioral, and social healthcare needs of our member population in which there is an inevitable need for holistic care.

In understanding that over 85,794 adults in Tennessee suffer from severe and persistent mental illness[1], Unison Health Plan actively provides behavioral health-informed case management services to these members in an effort to bridge the gap between our members' behavioral and physical healthcare needs. By recognizing that the healthcare outcomes of members with SED or SPMI can be exponentially improved by capitalizing on the integrated efforts of the various state agencies, the members' providers, family, and community resources, Unison's Special Needs Unit outreaches to members who present with certain indicators. Our specialized case managers outreach to all members who are identified as having a special needs indicator; therefore, we not only outreach to those members who are diagnosed with SED or SPMI but also those members with a less severe or progressive diagnosis but who still may require our support. Our case management support services focus on the immediate needs of the member, including the mobilization of community resources in an effort to reduce possible antagonizing social factors that may interfere with the maintenance of mental and physical health. By maintaining communication with the member until there is a demonstrated improvement in the members' health and the member's social or behavioral needs are satisfied, we ensure that the case management and community support presence has helped stabilize the members' health and decreased the likelihood that the lack of community resources is a factor in the deterioration of behavioral health.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

11 A 3 b) Unison Health Plan's Recommendations for Structural or Contractual Design Choices

Unison recommends the state contract the SED and SPMI population on a full-risk basis. The basis for this recommendation is our belief that the most effective way to ensure the greatest level of coordination is to structure the program so that one organization is ultimately accountable for a member's physical and behavioral healthcare outcomes. The contractual design or structure in Middle Tennessee should ensure that the new program specifically addresses the needs of people with SPMI/SED by including an enhanced benefit structure for those identified as SPMI/SED. We are willing to work with the state to structure the contract with the MCO in such a manner as to closely monitor and reward our success in maintaining the highest quality of care for these members.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from the proposal?

11 A 3 c) Unison Health Plan's Position on the Exclusion of SED and SPMI

While our preferred approach is to include the SED and SPMI population within the contract with the MCO, the decision to exclude this population will not negatively impact our interest level.

[1] NAMI Tennessee and the Campaign for the Mind of America, "A 'Shared State' of Mind: Finding Common Solutions for Funding of Mental Health Services in Tennessee," Data is according to U.S. Census 2000, March 2005.

d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

11 A 3 d) Unison Health Plan's Position on an Alternative, More Limited, No-Risk Arrangement

Although Unison Health Plan does prefer a full-risk arrangement, Unison's interest level in bidding on an alternative, limited or no-risk basis would not be negatively affected.

4. Please provide your experience working with essential community providers such as community clinics and community mental health agencies.

11 A 4) Unison Health Plan's Experience Working with Community Providers

Unison Health Plan has considerable experience working with community providers and is regularly recognized by state agency leaders as being a managed care organization that stands out among our competitors with respect to our outreach efforts.

The Special Needs Unit, the social and behavioral-health focused case management department, has extensive experience interfacing with the following types of organizations:

- Community Mental Health Centers
- Community Crisis Response Teams
- Inpatient and Residential Treatment Facilities
- Community resources dedicated to helping stabilize the member in their home and in the community
- Utility assistance organizations
- Indigent pharmacy programs
- Area agencies on aging
- Community resources to support disabled mobility.

As we partner with various community providers to ensure that the member is exhausting all possible resources that can help stabilize the member's health and improve the member's health outcomes and satisfaction with life, Unison also explores and connects the member with the following community programs:

- Supported employment programs to assist people in obtaining competitive employment
- Illness self-management programs to help the member take better care of themselves, manage symptoms, and learn new ways to cope better with their illness
- Family psychoeducation support for individuals with mental illness to achieve the best possible outcomes through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones.

In addition, Unison Health Plan recognizes the value of programs such as the Texas Medication Algorithm Project (TMAP) and a similar program implemented in state facilities in Pennsylvania called the Pennsylvania Medication Algorithm Project (PennMAP). The plan participates in a Pennsylvania BH/PH joint task force working to identify 'best practices' in therapeutic management as we adapt lessons learned in the residential settings for value in the outpatient settings. The task force focus is similar to the Missouri approach to incorporate educating practitioners on best practice in standard of mental health medications.

5. **Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?**

11 A 5) Unison Health Plan's Recommendations Regarding Design of Behavioral Health Proposal

Historically, the demand for behavioral healthcare services has been lost within the utilization data typically used to develop the premium paid to MCOs. This happens for many reasons, including: underutilization; underreporting; inappropriate coding of behavioral health treatment as physical health treatment; and services being provided under separately funded programs. Unison highly recommends the state make efforts within the rate development process to ensure appropriate funding is allocated at levels representing the desired level of service. Funding should be risk-adjusted and include appropriate trending and administrative cost and profit loads. As done with the dental program, the state may consider investing additional funding in an effort to reduce underutilization.

B. Pharmacy Services

Pharmacy has been a key driver of expenditure growth in the TennCare program. In an effort to control pharmacy costs, the State carved-out pharmacy and contracted with a pharmacy benefits manager (PBM). The State intends to continue the current PBM contract and the carve-out of pharmacy services. The MCO, in conjunction with the PBM, will support all efforts to manage the pharmacy benefit, including, but not limited to, provider education; identification and monitoring of outlier prescribers and users; and coordination of prescriptions across providers.

1. **Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.**

11 B 1) Unison Health Plan's Approach to a Pharmacy Carve-Out

Unison Health Plan believes that a fully integrated medical and pharmacy management program is the single most effective way to ensure the most cost-effective use of healthcare dollars, while maintaining the highest levels of quality.

It is our understanding that TennCare originally carved pharmacy out in order to minimize the per unit cost of the drug by maximizing rebates. Unison believes that MCOs can save the state more dollars by focusing on the appropriate utilization of services. As such, Unison recommends that TennCare carve the pharmacy benefit back to the MCO on a risk basis.

Under a pharmacy carve out, MCOs have only limited ability to affect cost containment strategies such as formulary compliance at the point of sale and real-time compliance with guidelines for chronic disease conditions such as diabetes and asthma. The MCO will use data to support disease and case management programs but is handicapped by not having information in time to affect care. For example, the information that a member fills a prescription for oral steroids is used by case managers to evaluate the member's treatment plans and asthma step-therapy plan. The non-provision of an inhaled steroid is used as an opportunity to intervene to help a member get controller medications to prevent costly ER and hospital visits. This data is of little use if obtained after the crisis has passed or when the respiratory season is over.

In the event that pharmacy remains carved out, it is critical that the state allow the health plan to share in pharmacy-related savings. This would encourage the MCO to implement programs and policies that focus on reducing total healthcare expenditures while maintaining the highest quality standards rather than simply reducing non-pharmacy related healthcare expenditures.

While a pharmacy carve out does limit the effect we can have on the total drug spend, we could implement the following strategies to promote more cost-efficient pharmacy management for those specific prescribers who are identified as outliers with respect to PDL compliance and brand prescribing:

- Create provider-specific reports on performance with detailed claims data to include comparison to peers, network, and program
- Pharmacist or Medical Director will review these reports and include suggestions for PDL alternatives and generic options or opportunities for improvement
- During first prescriber contact, mail all outliers identified in the first month's report
- If a prescriber is identified as an outlier in a second month reporting period, contact the prescriber via mail and have Medical Director contact the prescriber by telephone
- If a prescriber is identified as an outlier for three consecutive months, hand deliver feedback reports to the prescriber
- Track and trend the prescriber's overall network performance and individual performance
- Consider sanctions (up to dismissal from network) for prescribers who do not respond positively to feedback
- Consider identifying individual pharmacies or pharmacists for the same reporting parameters and will provide specific, detailed feedback each month for poorest performers' activity.

2. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

11 B 2) Unison Health Plan's Need for "Real-Time" Information for Pharmacy Benefit Management

In order to properly manage the pharmacy benefit in a carve-out scenario, the PBM would need to supply detailed daily override reports and prior authorization reports (non PDL drugs authorized by PBM) and a weekly electronic claims activity transmission that includes the following:

- Member name, ID, DOB, gender, address
- Prescriber name, ID, specialty, address
- Pharmacy ID, name, address, phone
- Drug dispensed, drug class (i.e. AHFS), QTY, Days supply, drug strength (label name), refills authorized
- New or refill
- Date of fill
- Generic, Brand, PDL, DAW, Non-preferred, non formulary indicators
- Claim override code (reason)
- Prior auth code (indicator)
- Lock-in codes
- Total amount paid, dispensing fee, ingredient cost.

C. Long-Term Care Services

Long-term care services (nursing facility and services through home and community based waivers) will be carved-out of the MCO benefit package. However, individuals

receiving long-term care services (including the aged, blind, and disabled population) will be enrolled in MCOs for their acute and behavioral health services.

1. **Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.**

11 C 1) Unison Health Plan's Care Coordination Procedures to Reduce Service Gaps and Duplication

Unison Health Plan recognizes our responsibility to coordinate healthcare services provided to those members who are also receiving long-term care services. To ensure that members receive the appropriate and most cost-effective healthcare services in a timely manner, Unison must not only understand the needs of our members in long-term care settings but also realize the needs and circumstances of the long-term care team members with whom we partner. By maintaining direct and open communication with the long-term care worker, Unison can better anticipate the needs of the member and provide a higher level of skill and expertise with respect to the member's healthcare needs. Ultimately, Unison's involvement with the member's healthcare results in preventing unnecessary hospitalizations or trips to the emergency room that are often the quickest and safest alternative for a long-term care worker who lacks the knowledge necessary to provide the member with appropriate healthcare.

Unison's long-term care coordination efforts focus on ensuring:

- Timely access to the appropriate level of care with the appropriate provider
- Educational outreach efforts to long-term care organization and staff.

Unison Health Plan's coordination efforts with respect to long-term care facilities also ensures that members in a long-term care setting receive the necessary follow-up assessments to determine if a long-term care setting is the most appropriate place for the member. Often, a member's healthcare status may change after the initial placement in the long-term care setting, yet they will remain in the long-term care facility as the family is not comfortable with other home-based care arrangements. As the family becomes more comfortable in dealing with the member's long-term care needs, Unison works with the family to move the member to a less restrictive setting.

2. **What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?**

11 C 2) Unison Health Plan's Incentive Recommendations

Unison recommends that TennCare establish a home- and community-based service utilization baseline and reward those MCOs with financial incentives that demonstrate increased utilization beyond this baseline. Unison recommends any financial incentive include sharing in savings resulting from these efforts.

D. EPSDT Services

As part of the TennCare Middle Region reform the State is focusing efforts on enhanced EPSDT screening rates and compliance with the periodicity schedule. The State is considering the use of incentives to reward MCOs that achieve specific targets.

1. **Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive**

programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

11 D 1) Unison Health Plan's Current EPSDT Service Approach

Unison Health Plan realizes that safeguarding the health of young members is an important responsibility and our EPSDT program is specifically designed to serve the Medicaid population. Unison Health Plan will identify all members who are due for a screening under the age of 21 for Medicaid. Once identified, we will assist these members to help them access the appropriate screening(s) and any follow-up care determined necessary through the exam. On a monthly basis, Unison Health Plan will distribute a roster to PCPs that identifies all assigned members who are due or overdue for a screening, and/or have not had a PCP encounter within a certain number of days of enrollment. PCPs will conduct EPSDT screenings according to the TENNderCARE Periodicity Schedule for screening, vision, hearing, and dental services.

Upon award of a contract in the Middle Tennessee region, we will perform a comprehensive assessment of regional variables that influence EPSDT screening and services, such as culture, language, transportation, provider availability, community resources, and education. Based on this assessment, we will fine tune our EPSDT outreach and education plan to ensure maximize success.

Our targeted outreach plans focus on members and providers. For providers, our efforts include use of office orientations and/or recognition for high immunization or preventive service rates, encounter reporting and program compliance. Multiple avenues identify and educate members about TENNderCARE screens and facilitate compliance with the periodicity schedule, including targeted mailings and telephone calls. After review of our comprehensive regional assessment, we may offer nominal, non-cash incentives to increase member compliance.

The EPSDT Outreach Team receives weekly reports**.** The new members reports will identify all newly enrolled Medicaid members under the age of 21. The EPSDT Outreach team uses these reports to develop lists for telephone contact attempts to the member's parent/guardian, pursuant to the following procedures for member contact.

The EPSDT Outreach team will also receive additional bi-weekly reports. We generate a report that identifies Medicaid members who are due for screening(s) based on their age, and/or the date of their last screening. As with new members, an outreach telephone call is made to the member’s home. If we cannot contact the member, an EPSDT letter including Unison Health Plan's phone number is mailed to the member. Once contact is made with the parent/guardian, the EPSDT Outreach Team:

- Explains the importance of preventive care, the periodicity schedule, and services available
- Informs them of how and where to access services, including available transportation
- Offers to make a three-way conference call to the PCPs office to schedule an appointment
- When an appointment is scheduled through the EPSDT Outreach Team, or if the parent or guardian already made an appointment, a reminder of the time, place and date of their upcoming appointment is sent
- If the parent or guardian declines to schedule an appointment during the call with the EPSDT Outreach Team, they are encouraged to make an appointment on their own. The parents or guardians are re-contacted to verify whether an appointment was scheduled and/or occurred.

At times we may encounter either a disconnected or incorrect telephone number when attempting to contact a member. To address this problem, whenever we contact a member, we verify their address and phone number. We also routinely gather secondary telephone numbers for our members, such as a mobile, work, or family members' phone numbers. If we are unable to contact a member, we document that fact in our system and a follow-up mailing is automatically generated explaining the reason for the EPSDT outreach call and requesting that the member or parent/guardian contact Unison Health Plan.

If a member mailing is returned as undeliverable, we verify the address in our system, and another attempt is made to reach the member (parent/guardian). As a final effort, we contact the member's PCP for any additional addresses, phone numbers or other contact information.

If appointment(s) are scheduled, the EPSDT Outreach Team confirms the appointment with the PCP's office and requests feedback as to whether the member keeps the appointment. If the PCP does not provide this feedback, Unison Health Plan will contact her/his office. If we cannot confirm that the member kept the appointment, she/he is placed on the call back schedule. If we confirm that the member did not keep the appointment, the EPSDT Outreach Team again contacts the member to schedule another EPSDT appointment.

E. Utilization Management/Medical Management (UM/MM)

Essential to controlling the current rate of TennCare expenditure growth is a comprehensive and successful utilization and medical management program. As described above, Tennessee intends to have service limits for various benefits, and the MCO will be responsible for managing care within those limits. The proposal currently before the Federal government would allow the State to implement "hard" benefit limits. The only exceptions would include services on the "short list", which would not count toward benefit limits and continue to be available to enrollees after benefit limits are hit. However, the State is considering moving toward "soft" benefit limits in the future, where services beyond the benefit limit could be provided as cost-effective alternatives to covered services. The MCO would have the lead role in deciding whether to provide services over the applicable benefit limits. The State expects that these services would be authorized using a prior authorization process.

1. **Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ "soft" limits and the general criteria that would be utilized to evaluate requests.**

11 E 1) Unison Health Plan's Managed Care Experience in a State with Benefit Limits

Unison Health Plan's recent experience in the implementation of benefit limits while serving the Pennsylvania Medical Assistance (Medicaid) population was a multi-step process. This process included the following elements:

- Data and financial analysis: Cost effectiveness versus member disruption
- Provider contractual conflicts
- Higher cost service in lieu of lower cost service limits
- Exception process development
- System modifications

- Member and provider education.

Based on state program-defined benefit limits, Unison analyzed current patterns of utilization which allowed initial identification of affected members. A more detailed analysis was performed to determine the characteristics of our membership such as age, risk category, and disease prevalence. Clinical and financial components weighted the effectiveness of hard limits versus longer term disease deterioration. Plan specific 'soft' limits were considered where contractual conflicts such as capitation arrangements could accommodate PCP visits beyond imposed limits so as to deter inappropriate use of emergency room services.

Unison considered the volume and characteristics of membership affected by each category of limit. Limits were bypassed in secondary situations where 'benefit less benefit' would result in no financial gain as opposed to member dissatisfaction. Other limits were determined to require an extended notice period to allow completion of previously authorized service (dental service) or proper transition of care (DME rental items).

Based on state mandated 'soft' limits, an exception process was established to allow member or provider requests for services beyond benefit limits. Unison developed an exception form to facilitate the collection of necessary information including medical evidence to support the type and number of services to be reviewed. A Medical Director review process would consider the totality of the member's needs to afford medically necessary services in lieu of posing serious harm or deterioration to the member's health or the provision of a more costly service in lieu of benefit exception. These 'soft' limits were a consideration in initial modification to rates subsequent to implementation of overall benefit package limitation; however the state and the MCOs concur that the actuarial assumptions will clearly need reevaluated after the 'true costs' of the exception process has been experienced.

Member and provider educational materials and early announcements can assist with a smooth transition. Additional care coordination efforts were provided through clinical and special needs case management services for specifically identified members that may be served with one-on-one coordination of care outreach efforts. Extensive training of team members and system modification must be considered to permit full functionality of imposed limitations. The plan published printed materials for general provider distribution as well as performed on-site orientations where necessary for specific provider types primarily affected by the new limits.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.

11 E 2) Unison Health Plan's Recommendations Regarding UM/MM Requirements

Unison Health Plan's experience with "soft" limits is that they are often difficult to administer and fraught with inconsistency. "Soft" limits usually require a determination, based on numerous characteristics of an individual's medical profile, as to whether an exception is warranted, thereby actually increasing, rather than decreasing the administrative actions and costs required to operate the program. In addition, because the exception process almost always includes due process rights in some form of administrative adjudication, consistent decision-making is difficult to ensure and inconsistent decisions may generate further litigation.

Therefore, Unison Health Plan recommends the state not implement "soft" benefit limits. If the state chooses to do so, Unison recommends the state cover the full cost of any medical services that result from a "soft" limit being overridden, thereby allowing for such costs to be excluded

from the premium paid to the MCO. However, if a "soft" limit approach is adopted and if the MCO will bear the cost of exceptions, actuarial soundness would require that rate development anticipate the expected cost of such exceptions.

F. Disease Management

Physical Health

The State intends to incorporate the principles of disease management into its reformed managed care program and a comprehensive and coordinated approach will be expected of all participating MCOs. At a minimum the expectation would be that the MCO apply disease management techniques to the following physical health conditions:

- **Diabetes mellitus**
- **Congestive heart failure**
- **Coronary artery disease**
- **Asthma**
- **Chronic-obstructive pulmonary disease**
- **High-risk obstetrics**

1. **Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs? Again, if yes, on which conditions does your program focus today?**

11 F 1) Unison Health Plan's Formal Disease Management Program Description

Unison Health Plan employs a formal disease management program in our Tennessee, Pennsylvania, Ohio, and South Carolina markets to focus on the following conditions

- Diabetes mellitus
- Asthma
- High-risk obstetrics.

While Unison does not employ formal disease management programs for congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease, we do employ targeted case management for these conditions. Unison would convert these targeted case management programs into formal disease management programs if awarded the Middle Tennessee business.

2. **Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.**

11 F 2) Unison Health Plan's Disease Management Program Administration

Unison Health Plan's disease management programs are fully performed within our organization and are not subcontracted.

3. **Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what**

additional health conditions you might recommend for targeted intervention techniques (e.g. obesity, pain management)?

11 F 3) Unison Health Plan's Disease Management Approach

Unison Health Plan's disease management programs were designed to address those chronic diseases, illnesses and conditions for which our dedicated clinical case management team frequently provides case management services and member education in an effort to control. The experience of our multidisciplinary team of clinical case managers, who are registered nurses, social workers, and medical directors, combined with the collection of certain health indicator data to identify the prevalence of frequently occurring symptoms associated with chronic diagnoses, has allowed Unison Health Plan to establish our targeted disease management approach. This approach consists of dedicated efforts involving case management, care coordination, and member education to promote optimal health outcomes, prevent unnecessary visits to the emergency room or hospital, and build bridges between the member, his or her primary care providers, specialists, family members, and community service agencies.

Unison's experiences and careful analysis of member data has led us to design formalized disease management programs to address the needs of our member population who frequently suffer from the debilitating effects of:

- Diabetes mellitus
- Asthma
- High-risk obstetrics.

Unison Health Plan's Disease Management Programs

Diabetes Mellitus

Program Summary

Unison Health Plan's disease management program for diabetes mellitus focuses on education and improved compliance with the physician's treatment plan. Patients are primarily identified through claims and pharmacy activity but as with all of the programs, members, treating physicians and Unison's Utilization Management department are also strong referral sources. Each member is assessed, stratified and the care plan is customized to meet each member's needs. Members that require limited assistance will receive educational mailings. Unison's clinical case managers will develop a more comprehensive care plan that includes frequent outreach to both the member who requires a more intense approach and his or her treating physician.

Population Identification

A total of 11,507 members are currently being served by Unison's Diabetes Health Management program. Identification criteria are examined on a quarterly basis and include the following codes:
Medical Claim Diagnosis: Diabetes will be defined based on ICD-9CM code of 250.xx or 357.2 or 362.0 or 366.41 or 648.0 reported as either the primary, second and third diagnosis
Insulin prescription: Any pharmacy claim for medication classified under the therapeutic grouping Insulin (INJ, OTX)
Oral hypoglycemic/antihyperglycemic prescription: Any pharmacy claim for medication classified under the therapeutic grouping Oral Hypoglycemics (RX).

Asthma

Program Summary

Unison Health Plan's disease management program for asthma focuses on children and adults with moderate to severe asthma and places a heavy emphasis on improving the quality of life,

patient education and the increased usage of long-term control medications. Each member is assessed, stratified and the care plan is customized to meet each member's needs. Members that require limited assistance will receive educational mailings. Unison's clinical case managers will develop a more comprehensive care plan that includes frequent outreach to both the member who requires a more intense approach and his or her treating physician.

Population Identification

Our asthma health management program currently serves a total of 5,432 members with 882 of these members having a diagnosis of chronic obstructive pulmonary disease. Identification criteria are examined on a quarterly basis and include the following codes:

Medical Claim Diagnosis: Moderate to severe asthma will be defined based on ICD-9CM code of 493.xx only if reported as the primary diagnosis on any medical claims
Short Acting Bronchodilator Prescription and a medical claim
Long-Acting Beta Agonist Prescription and a medical claim
Inhaled Corticosteroid, Cromolyn, Nedocromil or Leukotriene Modifiers Prescription

High-Risk Obstetrics

Program Summary and Population Identification

Our high-risk pregnancy health management program serves a total of 9,430 members. Unison Health Plan's high-risk obstetrics program (also known as our high-risk pregnancy program) partners with the *Miracles* program which incorporates the use of a "buddy" system in which a non-clinical team member partners with a pregnant member throughout the duration of the member's pregnancy to support the member and to encourage the member to receive the appropriate prenatal care. Pregnant members identified as high-risk, primarily through the OB/GYN physician's submission of the OB Needs Assessment Form completed during the first prenatal visit, are referred to clinical case management by registered nurses. The assessment form is designed to clearly identify members that are at risk of pre-term labor or a poor outcome of the pregnancy. High risk pregnancy indicators are as follows:

- Teen pregnancy – age 17 and under
- Pre-term labor
- Premature rupture of membranes/cervical dilation
- Uncontrolled insulin dependent diabetes
- Fetal anomalies
- Placental/uterine abnormalities
- Hyper-emesis
- Incompetent cervix
- Uncontrolled asthma
- Uncontrolled or chronic hypertension/pregnancy induced
- Hypertension
- Preeclampsia
- Multiple gestation
- History of three or more previous miscarriages after first trimester
- Bleeding after first trimester
- Current drug or alcohol abuse.

Unison's Disease Management Programs

Assessment Tools

The initial case management call provides for one-on-one explanation of services available through case management and at this time offers the member the opportunity to opt-in to case

management. The case manager will provide the member and/or parent/guardian his/her phone number for future contact. Program participation is not mandatory and each member may choose to decline case management services. Consideration is given to the circumstances surrounding the patient's refusal and he/she may be scheduled for periodic outbound phone calls to ask the patient to reconsider.

Upon member acceptance of clinical case management, letters will be mailed to the Primary Care Physician (PCP) and the patient to serve as confirmation of the initiation of case management services.

Care Plan Development

Once the member has accepted case management and the initial assessment tool is completed, the case manager will create a care plan. The initial assessment will help identify the issues necessary to formulate the care plan; the member must agree to the goals and intensity of services by the case manager in order for a successful outcome. Each treating physician is notified in writing and by telephone, at the time of their patient's enrollment into the case management program, to participate in the initial and ongoing development of the care plan. Predetermined timeframes for the completion of the care plan are audited by the case management supervisor on a routine basis.

Upon completion of the care plan the member is risk stratified by utilizing the responses to the assessment tool and data obtained from Utilization Management and claims activity reports. If the member accesses certain plan services at any time, this activity alone can re-stratify the member but the case manager has the ultimate responsibility for determining the level of interventions necessary to achieve the optimum outcomes for his/her patient.

General stratification levels are described below:

Case Management Stratification

Level One / Short term: These members have pharmacy and/or one ER visit in the past six months. Members/caregivers who are independent with their condition and demonstrate an understanding of the care and ordering treatment plan. They require minimal intervention, support and education as identified on the initial assessment tool.
Level Two: These members have more than one hospital admission or more than two ER visits in the past six months. Members/caregivers who are independent with care but need help understanding the importance of self-management of the condition. Outcome: care givers/member becomes self-independent in their care.
Level Three: These members were admitted into the intensive care unit, or more than two hospital admissions or more than four ER visits in the past six months. Members/caregivers with any recent catastrophic illness(s) or chronic conditions with readmission and frequent emergency room visits. Outcome: to identify the factors and develop a preventive plan with the member's medical team that assesses progress.

Interventions

The interventions described below are core interventions that were developed to allow the case manager to customize to meet the individual member's needs and the specific disease/condition. Several case management programs such as transplant, wound, NICU and high-risk pregnancy have unique member goals and/or interventions.

Members who are designated as Level One receive:

- Outreach calls with frequency being determined by the case manager through assessment
- Contact and coordination with physician(s), and other healthcare team members as indicated. Clinical case managers contact the treating physician's office after the member has accepted case management services and the physician has been notified of the case manager's name and phone number and given the opportunity to collaborate on care plan development
- A welcome letter that the treating physician also receives if applicable
- Educational and instructional material if applicable
- Quarterly mailings specific to the disease or case management program
- If indicated, referral to another case management program.

Members who are designated as Level Two receive:

- All Level One interventions, if applicable
- Outreach call to caregivers or member every two to three months or more frequently to assess and evaluate the member's progression or challenges, compliance with the treatment plan (as ordered by the physician(s)), medical appointments and other support services as indicated by physician orders/service requests
- Home healthcare evaluation/services, if indicated, can be requested if treating physician and member agree
- Contact and coordination with physician(s), and other healthcare team members as indicated
- Education on illness, disease process, preventive measures, co-morbid conditions and risk factors that would hinder the member to reach the optimal level
- Quality of life assessment, every 6 months, where applicable.

Members who are designated as Level Three or Level Four receive:

- All Level One and Level Two interventions, if applicable
- Outreach calls every month or more frequently as assessed by the case manager in meeting the case management needs.

Provider Involvement

Unison Health Plan recognizes the importance of including the treating physician and using their medical expertise in the continued refinement of our disease management programs. Unison Health Plan clinical case managers outreach to physicians to actively engage and involve them in the following manners:

- Each treating physician is notified in writing and by telephone at the time of their patient's enrollment in the disease or targeted case management program and is invited at that time to participate in the initial and ongoing development of the care plan. The case manager may contact the primary treating physician in order to design specific interventions in conjunction with the practitioner's treatment plan. This is also considered as an opportunity by the case manager to develop a relationship with the treating physician and his office staff
- The case managers contact the treating physician with any serious changes in member condition to update/redirect the plan
- The treating physician of members who are involved in the *Round Table* activities receive feedback after the initial Round Table discussion from case managers and/or a Medical Director to continually strategize the member's care plan

- Physicians receive a quarterly roster of their members accompanied by a patient profile or "Report Card" (for certain programs) that provides relevant member-specific medical information such as condition monitoring, adherence to treatment plans and identification of co-morbid conditions for several of the case management programs
- Primary Care Physicians and specialists provide input into the program through committee participation, and assist to develop and revise clinical guidelines
- Annually, physicians receive disease management program description information that outlines key activities that illustrate program services including case management services and identifies how the plan works with both the physician and the member
- Information describing the case management programs, which is communicated to plan physicians during Provider Relations office orientations, can be found in the provider manual, on the company website as well as described in periodic articles in the physician newsletter
- Physicians who score high results on the Report Cards are highlighted in Provider and QI Newsletters as "Best Practices"
- Physicians are strongly encouraged to refer patients to case management on an as needed basis by using the form and process outlined in the provider manual.

Unison Health Plan's Experience and Approach to Disease Management within the Context of Benefit Limits

Currently Unison Health Plan is serving over 200,000 Medicaid members under the Pennsylvania program with benefit limitations. An exception process was established to allow requests for services beyond benefit limits through the development of an exception form to collect necessary information including medical evidence to support the type and number of services. Unison's case managers serve as an integral part of disease management and act as liaison with involved providers to facilitate any benefit limit exceptions. A medical director review process considers the totality of the member's needs to afford medically necessary services in lieu of posing serious harm or deterioration to the member's health or the provision of a more costly service in lieu of benefit exception. The case managers and medical directors closely monitor non-compliance of member's care management due to benefit limits and proactively address these concerns with the primary care manager (PCP or specialist).

Unison Health Plan's Measurable Outcome Description Resulting From Disease Management Intervention

Our affiliated Pennsylvania HMO's diabetes mellitus, asthma, and high-risk obstetrics program (also known as Unison's high-risk pregnancy program), all of which are supported by case management, were instrumental in our being awarded a 3-year "Excellent" NCQA accreditation in 2002. Unison Health Plan is proposing to offer all three of the above-mentioned disease management programs, as well as programs specific to sickle cell anemia and hypertension, and congestive heart failure, coronary artery disease, and chronic-obstructive pulmonary disease.

The following is reflective of measurable results related to the disease management programs currently employed by our affiliated Pennsylvania HMO. We are confident that Unison Health Plan of Tennessee will meet or exceed these outcomes.

Summary of Clinical Outcome Measurements HEDIS ® and Current Benchmark for the PA Medicaid Plan, Reporting Years 2003, 2004, 2005

Program	Description	2003	2004	2005	2005 Accreditation Score	2005 Accreditation Benchmark - 90th Percentile
Diabetes	% HbA1c Screening	74.45%	76.89%	78.10%	83.10%	83.00%
	% Poor HbA1c Control (>9)	38.69%	36.74%	37.71%		
	% Eye Exam	54.01%	53.53%	58.39%	63.39%	60.00%
	% LDL Screening	75.18%	82.00%	83.70%	88.70%	74.00%
	% LDL <130mg/dL	49.39%	56.93%	58.64%		
	% LDL <100 mg/dL	30.41%	29.20%	36.25%		
	% Nephropathy Screening	50.36%	46.40%	49.15%	54.15%	54.00%
Asthma	Use of Appropriate Medications ages 5-9	66.55%	70.20%	64.91%		
	Use of Appropriate Medications ages 10-17	63.94%	64.80%	64.29%		
	Use of Appropriate Medications ages 18-56	70.03%	72.99%	69.65%		
	Use of Appropriate Medications ages 5-56	68.28%	70.63%	67.61%	72.61%	71.00%
Pregnancy	Timeliness of Prenatal Care	89.54%	89.78%	89.54%	94.54%	88.00%
	Frequency of Prenatal Care Visits (>81%)	68.13%	77.62%	82.73%		
	Post Partum care	56.93%	55.23%	58.64%	63.64%	67.00%

Like care coordination and case management activities, the savings created by disease management programs are difficult to precisely determine. We will continue to monitor developments in the industry regarding improved techniques to measure the return on investment generated by such programs. However, anecdotal evidence drives our confidence in the ability of disease management programs to generate savings. Not only do our disease management programs take advantage of payment rate differentials to generate savings, but the HEDIS results, which demonstrate improved preventive healthcare for members in those programs, further confirm such savings. While it may be difficult to quantify the total cost saved when an inpatient admission or emergency room visit of severe complication is avoided due to successful preventive medicine, the savings generated are genuine.

Unison Health Plan's Case Management Programs

Congestive Heart Failure, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease as Part of Unison's Comprehensive, Targeted Adult Case Management Program

As discussed earlier, Unison Health Plan's formal disease management techniques are incorporated into intensive case management programs in order to address the systemic needs of our members suffering from congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease. These specific case management interventions, which are

available as part of Unison's Adult Case Management Program, are customized for each member to ensure that the members' primary diagnosis and resulting symptoms are specifically targeted.

The Adult Case Management Program identifies and risk-stratifies the adult medically complex population with consideration to co-morbid conditions and social environment. Activities are designed to address members within the continuum of their disease, including educational outreach, ongoing-targeted short and long-term case management, as well as collaboration with the member's physician and other healthcare team members to effectively educate and develop an optimal treatment plan to help the member manage their disease.

The Adult Case Management Program includes the diagnoses listed below but this program is not limited in scope. As members present with other diseases, illnesses, or conditions, which are not listed below, the clinical case manager will ensure that the member receives the appropriate case management intervention on behalf of Unison's Adult Case Management Program in order to address the members' unique needs. Therefore, Unison would recommend the additional health conditions listed below for targeted intervention techniques:

- Congestive heart failure
- Coronary artery disease
- Chronic Obstructive Pulmonary Disease
- Other circulatory & respiratory conditions
- Obesity
- Chronic pain
- AIDS/HIV
- Anemia/Sickle Cell
- Multiple Sclerosis/Epilepsy/Paralysis
- Trauma
- Spinal Cord/Head Injuries
- Neoplasms
- Other Catastrophic conditions

The inpatient utilization management includes a process that requires the Utilization Management nurse to screen and refer patients with pre-identified diseases/conditions for short-term case management services. Short-term case management is defined as a hospital admission that has created a change in the member's discharge status that could require additional monitoring and support for a designated period of time.

The Adult Case Management Program includes a review of utilization and claims data that identify co-morbid conditions within the member's disease/condition. Annual claims reports for the previous year's total member population are reviewed to determine the prevalence of co-morbid conditions that would qualify for certain case management programs. The top two co-morbid conditions are ranked by claims volume. The program then provides education and counseling for these conditions as part of the overall program intervention. This intervention includes targeted education to those with the co-morbidities and those at risk of developing the conditions. As the prevalence of one condition that would qualify a member for the Adult Case Management Program may indicate the existence of other symptoms, members must consider other healthcare issues that may be attributable to the incidence of their disease/condition.

Behavioral Health

In addition, the following behavioral health conditions are targeted for care management interventions:

- **Schizophrenia**
- **Bipolar disorder**
- **Major depression**
- **Co-occurring mental illness/substance abuse**

4. **Does your care management program include behavioral health conditions? If yes, where is it currently being used?**

11 F 4) Unison's Care Management Program With Respect to Behavioral Health Conditions

Unison has taken a broad approach to behavioral healthcare management, offering case management services to members identified with special needs inclusive of behavioral health conditions, mental retardation, development disabilities and substance/alcohol abuse issues. Unison staffs its Special Needs Unit with case managers who have educational backgrounds and experience specific to behavioral health with an emphasis on adult issues, child/adolescent issues, and family systems-based issues. Unison utilizes the resources of its Special Needs Units in all markets and products, including those where we are directly responsible for managing behavioral health services, those where we subcontract behavioral health services, and those were we only coordinate behavioral health services.

5. **Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.**

11 F 5) Unison Health Plan's Behavioral Health Care Management Administration

The behavioral health case management described above is performed within our organization. However, Unison does contract with behavioral health vendors in certain markets to provide network access and formal disease management programs to include:

- Schizophrenia
- Bipolar disorder
- Major depression
- Co-occurring mental illness/substance abuse

Care coordination between physical and behavioral health providers remains the responsibility of Unison's dedicated Special Needs Unit, who will identify, refer, and monitor members enrolled in these programs.

6. **Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.**

11 F 6) Unison Health Plan's Description of our Care Management Approach

Unison Health Plan recognizes the quality of life experienced by members impacted by behavioral health issues is directly related to the quality, availability and management of interventions for these issues. As previously described, Unison's experience providing case management to Medicaid members who are impacted by behavioral health issues is extensive though generalized across all behavioral health issues with a focus on assisting members in

accessing their physical and behavioral health benefits, community supports and focused interventions as available and accessible in their communities.

Unison is specifically interested in supporting existing services and working with communities to assist and guide the development of services widely recognized as essential such as:

- Crisis response
- Intensive case management
- Diagnosis-specific psychotherapeutic interventions
- Detoxification services
- Inpatient treatment
- Residential treatment
- Illness self-management
- Psychotropic medication availability and management based on best practices and recognized research (i.e., medication algorithms)
- Supportive housing
- Supportive employment
- Medication support (i.e., administration, education)
- Other support services
- Incarceration diversion
- Post incarceration reintegration
- Family psycho-education
- Community-based treatment

Unison has a strong history of identifying and using clinical guidelines for various health conditions. Specifically, Unison would employ clinical practice guidelines promulgated by the American Psychiatric Association for Schizophrenia, bipolar disorder and major depression. The dually-diagnosed member population will require an agile seamless system of care delivery between behavioral health and physical health providers. This system of care delivery will be created through education and identification of providers able and willing to function within this environment that requires flexibility and an expanded knowledge base to meet the unique needs of the dual-diagnosed member.

Unison will identify members in need of disease management interventions using the following information:

- Claims, clinical authorizations
- Pharmacy
- Diagnosis indicators of co-morbidities.

Unison will continue its efforts to reach members utilizing internal, provider and community-based resources. Specifically, Unison will use the following methods to provide outreach and education:

- Telephonic outreach
- Use of community resources to make person-to-person contact with members
- Engage providers that serve the educational and outreach needs identified by Unison as it meets the behavioral health needs of members
- Utilize Health Education Advisory committee to identify the education needs of the community along with strategies that are community-specific to meet those needs.

Unison will guide, measure and manage the performance of its providers in order to provide the best service to its membership. Unison will accomplish this by:

- Providing clinical practice guidelines to its providers
- Measure providers against the performance expectations outlined in the clinical practice guidelines
- Report to providers their performance against clinical guidelines via provider report cards

- Support provider and community education on clinically identified themes based on identified patterns of performance.

Unison will continue to strive to attract staff that is qualified by credential and experience to provide the credible guidance to the provider community as well as the membership. Specifically, Unison currently uses case managers who have educational backgrounds in behavioral health along with varied direct experience working with this population. Unison also provides clinical direction to its case managers using a behavioral health-licensed clinical professional.

Unison directly manages or coordinates the behavioral healthcare services of almost 300,000 members in our various markets.

While complex, Unison has experienced operational success with implementing both “soft” and “hard” benefit limits. However, for reasons discussed at length within this document, Unison does not recommend that the state adopt "soft" benefit limits.

Outcomes measures would include those that monitor utilization, program completion, functioning, symptom reduction, expense, and satisfaction.

Unison prides itself as having extensive experience managing member’s needs within benefit limits and will extend this knowledge to the provision of behavioral health benefits.

G. Capitation Model

Under the TennCare reformed managed care model the State will be returning to capitated managed care.

1. **Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.**

11 G 1) Unison Health Plan's Operational Experience under a Risk Contract for Medicaid

Unison Health Plan operates under full-risk capitation in Pennsylvania, South Carolina, and Ohio. In addition, Unison Health Plan of Tennessee, Inc. operated under full-risk capitation prior to entering the non-risk period. We have experienced a great deal of success with full-risk capitation and are excited about the opportunity to return to full-risk capitation in our Tennessee market. We recommend the state fully consider the expected costs and utilization while developing its rates to ensure actuarial soundness requirements are met. Further, we believe that sound actuarial assumptions are a critical part of attracting health plans with a proven track record into the Middle Tennessee region.

2. **Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.**

11 G 2) Unison Health Plan's Position on Participating in a Full-Risk Capitation Environment

Unison Health Plan of Tennessee, Inc. looks forward to returning to full-risk capitation.

3. **The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:**

    a. **State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)**
    b. **If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)**
    c. **If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the state reimburses X% of costs in excess of X% of capitation payments)**
    d. **Other**

11 G 3) Unison Health Plan's Risk Arrangement Preference

Unison Health Plan of Tennessee, Inc. prefers full-risk capitation. Given the complexities of determining actuarial sound rates in a "soft" limit environment, we recommend the state not impose "soft" limits. If the state chooses to do so, Unison recommends the state cover the full cost of any medical services that result from a "soft" limit being overridden. In turn, these costs should not be considered within the premium paid to the MCO.

4. **Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?**

11 G 4) Unison Health Plan's Participation With Respect to Number of Covered Lives

Unison Health Plan of Tennessee, Inc.'s minimum number of covered lives is considered on a market-by-market basis, however, we hope to serve at least 50,000 additional lives in Middle Tennessee.

H. Data and Systems Capability

Critical to the success of the program is the availability of robust, timely data, including encounter data, for use by the State and MCOs to manage and monitor the program. The State is very interested in MCO capacity to obtain and provide data and reports to the State, and capacity to use data for ongoing program monitoring and quality assurance.

1. **Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.**

11 H 1) Unison Health Plan's Description of Data Produced for External Monitoring

As a current vendor to programs in Pennsylvania, South Carolina, Tennessee and Ohio, we collect, retain, and report detailed information regarding members, providers, and healthcare operations on a regular basis. We currently provide numerous daily, monthly, quarterly, annual, and ad hoc reports for our covering agencies including, but not limited to, financial, enrollment, encounter/claims processing timeliness and accuracy, provider, case management, quality

improvement, utilization management, EPSDT, grievance/complaint/appeal, and fraud and abuse reports. The following is a condensed listing of reports submitted for external monitoring. A more detailed listing will be provided upon request.

External Monitoring Reports

- Annual HEDIS reports
- Annual external quality review reports
- Quarterly/annual inpatient/outpatient utilization reports
- Quarterly dental reports
- Annual obstetrical report
- Quarterly financial reports
- Annual financial reports
- Multiple quarterly provider reports
- Prompt payment analysis reports
- Monthly HHC reports
- Monthly authorization reports
- Language reports
- Cost utilization reports
- Ethnicity reports
- Quarterly EPSDT report: compliance rates
- Multiple quarterly utilization reports
- Network adequacy reports
- Monthly PCP capacity reports
- Quarterly utilization reports
- Quarterly health cost reports
- Encounter reporting (medical, hospital, dental, and pharmacy).

2. **Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.**

11 H 2) Unison Health Plan's Performance-Related Data Description

Unison Health Plan's Quality Improvement program tracks selected indicators of performance of network providers and subcontractors to identify areas that require further evaluation and possible improvement. These indicators cover program, clinical, and service activities and are selected based on an analysis of encounter data, member demographic information, and results of HEDIS, CAHPS, and External Quality Review (EQR) measurement outcomes. Additional indicators are included to meet contract requirements and recommendations made by the NCQA.

The following clinical and non-clinical indicators are reviewed and evaluated as part of Unison Health Plan's continuous Quality Improvement program.

Indicator	Evaluation
Non-Clinical:	
Provider access	Complaint data, on-site reviews, and random calls to provider offices
Provider availability	Geographic accessibility software mapping results
Member satisfaction	CAHPS survey results, complaints and grievances and appeals received
Provider satisfaction	Provider survey results and complaints received
Member and provider services staff access	Telephone call tracking data for abandonment rates and speed to answer
Credentialing / recredentialing standards and processes	Adherence to standards and timeframes

Indicator	Evaluation
Clinical:	
Provider adherence to clinical practice guidelines	Measurement of guidelines using appropriate study methodology of process indicators
Preventive health measures	HEDIS measures and chart audits
Continuity and coordination of care	Chart audits, and a survey of PCPs to assess appropriate communication and feedback from specialists, home health agencies, skilled nursing facilities, and inpatient hospitalizations
Quality of care	Sentinel events and member complaints
Patient safety	Drug interactions/medication safety, site reviews, sentinel events, hospital surveys, and nursing home care
Disease management program process and success	Process and outcomes indicators such as HEDIS measures and utilization indicators
Health promotion services	HEDIS measures, chart audits, and clinical guideline measures

Controlling Under- and Over-Utilization

Unison Health Plan carefully monitors utilization of healthcare services to identify trends that indicate a lack of compliance or understanding of protocols with respect to the use of emergency and referral services. Special consideration is also given to the identification of real and/or perceived barriers to emergency, specialty, and primary care services.

PCP Monitoring

PCP referral and authorization patterns are monitored on an ongoing basis, including an evaluation of whether they are consulting with specialty physicians and referring to emergency rooms when appropriate.

In addition, encounter auditing is conducted on a sample of PCPs to identify unusual or inappropriate practice patterns. Once the sample is selected, Provider Relations Representatives obtain the necessary medical documentation and conduct an audit to identify specific instances of missing, incomplete, or inaccurate encounter data.

Overall, our participating PCPs are monitored through the use of Provider Profiles or Network Management Reports, which evaluate practice-specific data to identify areas of over- and under-utilization. Provider Profile reports include utilization indicators in the areas of:

- Inpatient
- Specialist
- Emergency Room
- Other (including EPSDT)
- Non-par specialty referrals
- PCP
- Ancillary Services

The reports are used to determine outlier physicians who perform poorly and who may be visited by our Provider Relations Representatives and/or Medical Director. The visit will include discussions of the Provider Profile report and other practice-specific analysis reports described below. The report is presented to the physician and important findings are discussed. Physician-specific recommendations are made and progress is followed on subsequent visits. Physicians who show no signs of improvement may be brought to the Credentialing Committee for disciplinary action, up to and including termination from the Plan.

The PCP Management team also identifies best practices using provider encounter data and provides benchmarks from which to help poor performers improve operations.

Practice-Specific Analysis Reports

Institutional Claims

The Institutional Claims report gives the medical loss ratio for several recent quarters and charges for many classes of service. The per member per month (PMPM) cost for each class of service is listed as well. This report is most useful when compared to earlier results. Benchmark PMPM data are presented to help the physician understand the significance of his or her scores.

Specialty Referrals

This report lists volume overall compared to peers and further drill down reports allow analysis by specialty and/or by member to determine appropriate of referral patterns. In addition out-of-network referrals patterns are analyzed.

Hospital Admissions for the Past Quarter

This report lists each admission by hospital, diagnosis, date, primary procedure used, length of stay, and net cost of each admission. This report is useful when viewed in comparison with earlier time periods.

Emergency Room Encounters

This report lists the emergency room encounters for each member on the physician's roster, giving the date of service, procedures rendered and claim payment status for each visit.

Pharmacy Generic and PDL Utilization

This report lists the provider compliance with pharmacy initiatives.

I. Net Worth and Restricted Deposit Requirements

In addition to the statutory net worth and restricted deposit requirements for HMOs. TennCare MCOs must comply with contractual net worth and restricted deposit requirements. The statutory net worth requirement is made on an annual basis based on historical data (see TCA, Section 56-32-212). The MCO contract requires that the minimum statutory net worth requirement be recalculated before a significant enrollment expansion occurs. In terms of reserves, statutorily MCOs must maintain a restricted deposit in the amount of $900,000 plus specified amounts of premium revenue in excess of $20 million (see TCA, Section 56-32-212). The MCO contract requires MCOs to maintain a restricted deposit equal to the statutory net worth requirement. This requirement will be revised to clarify that the increased restricted deposit amount shall be calculated based on the MCO's TennCare revenue, unless that amount is less than the restricted deposit required by statute. If the amount calculated using only TennCare revenue is less than the restricted deposit amount required by statute, then the contractually required amount shall be equal to the restricted deposit required by statute.

1. **Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.**

11 I 1) Unison Health Plan's Position on Net Worth and Depositing Requirements

Unison Health Plan of Tennessee, Inc. is currently meeting these requirements in the West Tennessee region and will not consider them to be a deterrent to contracting with TennCare for the Middle Tennessee region.

J. Implementation Timeframe

The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.

1. **Does this anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?**

11 J 1) Unison Health Plan's Position on the Program's Anticipated Timeframe

The anticipated timeframe of an April 2006 contract award and an October 2006 implementation date does not impact Unison Health Plan's decision to participate in the program.

2. **Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?**

11 J 2) Unison Health Plan's Suggestions and Recommendations for Procurement and Implementation Timeframe

As Unison Health Plan is fully operational and currently serving members in the West Tennessee region, we believe that the state's procurement and implementation timeframe is reasonable. During the six month timeframe between contract award and implementation, we will continue to expand our provider network and our relationships with community providers to ensure that our members in the Middle Tennessee region have the highest degree of healthcare access.

Unison Health Plan would recommend that contract procurement not be dependent upon a contracted provider network, but that the provider network be evaluated and approved by the state prior to the October 2006 implementation date.